Mothering in Medicine: Parenting Policies in Canadian Medical Education

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Abstract

In 2005, 59% of Canadian medical school students were female. The feminization of medicine has brought many changes to the field including the utilization and creation of policies in support of women who chose to become parents during their medical training. This paper explores the institutional atmosphere in support of student parents in medical school and residency training in Canada.

Résumé

En 2005, 59% des étudiants dans les école de médecine au Canada étaient des femmes. La feminisation de la medicine a apporté beaucoup de changements dans le domaine y compris l'utilisation et la creation de politiques pour appuyer les femmes qui ont choisi de devenir mère pendant leur formation en médecine. Cet article explore l'atmosphere institutionnelle pour l'appui des étudiantes parents qui sont en medicine et en stage de residence au Canada.

Balancing professional responsibilities and child-bearing / child-raising is a pervasive daily activity for many women. Women working in the medical field are no exception and neither are students in medical education. As more and more women choose to become physicians, the reality of parenting while in medicine and in medical school is increasing in frequency.

In 2005 almost 50% of students in undergraduate medicine in the United States were women ("Educational Programs" 2005) while in the United Kingdom females made up 58% of undergraduate and graduate medical students ("Students in Higher Education" 2005). Canadian medical schools had a similar gender distribution in undergraduate medical education with the percentage of female medical students steadily increasing from 17% in 1970 to 59% in 2005 (*Canadian Medical Education* 2005).

The birth rate is in decline in Canada, with a record low of 10.5 live births per 1000 population in 2002 (*Births* 2004). Women are having fewer children and having their first child at a much later age. The average age of women giving birth in Canada in 2004 was 29.7 years and women having children over the age of 35 is four times more common now than it was a generation ago (*Births* 2004). Women are often delaying partnering (marriage, common law, same sex partner) and childbearing. As is the case of women in the field of medicine, many are pursuing professional careers which demand more time in university or in the work force before time can be taken for parenting.

A recent study in the United States found that 42% of women physicians with children had them during medical training (Potee *et al.* 1999). In addition it was reported that greater absolute numbers and percentages of women had children earlier in their medical career and it was predicted that

more women would have children during their medical training in the future. This is partly due to factors such as the later age of students starting medical training, an increase in the numbers of role models and institutional support (Potee *et al.* 1999). In Canada the majority of female medical graduates are in their late 20s upon graduation (*Canadian Medical Education* 2005) and then they embark on another 2-7 years of residency and fellowship training. In Canada in 2004, the majority of births occurred to women aged 25-34 (*Births* 2004). Thus, it follows that the timing of undergraduate and postgraduate medical training coincides with the child-bearing years for the majority of women in Canada.

Traditional medical school institutional policies, schedules and expectations have not been family-friendly and have posed difficulties for male and female students with families at the undergraduate and graduate level. Sleep deprivation, unpredictable work hours, difficult child care arrangements, lack of flexibility and hostility from colleagues are some of the problems faced by student-parents in medicine (Finch 2003). In particular, the inherent role of women in child-bearing and breastfeeding and traditional expectations for mothering pose significantly different challenges for female students compared to their male counterparts and continue to challenge modern policies and practices in medical education.

Undergraduate medical school programs in Canada vary somewhat in their length (3-4 years) and their program layout. However, they share a basic structure of classroom didactic or small group learning with some limited patient contact during the first year or two of the program and then a clinical clerkship component for the final one to two years. The clinical clerkship involves rotating through different medical specialities in hospitals and community clinic settings and being directly involved in patient care. This includes being on call overnight in a hospital and work shifts that can extend to 28 hours every 4th day. In some specialities the work day starts as early as 6:30am and there is little guarantee about when it will end. These demands do not end when medical school is done. They are presented here as an example of the level of responsibility and commitment which is required (and expected) of physicians.

Postgraduate medicine programs also vary across the country and by speciality. Residents in Family Medicine embark on a 2 year program combining time in community clinics and hospital wards focused on their future patient populations, as well as rotations through many specialities. Residents provide patient care service during these rotations as well as gain valuable clinical experience. Five year residency programs are common for specialties such as Internal Medicine, Psychiatry, Emergency Medicine and Surgery. Some residents also choose to do fellowships in subspecialties, adding even more time to their postgraduate training. Postgraduate medicine programs employ the residents with a negotiated pay scale. They are protected by provincial or regional unions and have benefits.

Women in medical training have access to benefits and salaries during their residency programs and access to financially significant personal loans and lines of credit during their undergraduate and postgraduate programs. Although the debt load accrued through tuition and limited employment possibilities as a medical student represents a financial burden for this population, there is privileged access to loan funding and a stable salary as training continues. Even though this paper focuses on the parenting challenges for a privileged class of women, the work demands and rigid training expectations in this field make the balance between work and parenting a significant challenge.

Medical schools in Canada have an important role to play in contributing to the success of women in medicine through the creation of explicit parenting policies in faculties of medicine, for both undergraduate and postgraduate students. Although not all women want to have a family and pursue medical training simultaneously, it is important to create a hospitable learning environment

for women by supporting those who do have this dual role (Palepu and Herbert 2002). Gender equity is not achieved through simply having increasing numbers of women studying medicine; the career and family aspirations of women must be considered, supported, welcomed, and facilitated.

The changing role of men in parenting also needs to be acknowledged. Medical students of both sexes and of various family compositions are looking for a better balance between their family lives and academic pursuits and improvements in parenting policies in medical training will benefit both male and female student parents.

In this paper I explore the institutional atmosphere across the country for parents in medical education in Canada by providing a description of some of the current support policies available to them at the undergraduate and graduate levels. It serves as a wake-up call to professional education programs that are attracting increasing numbers of mature students by arguing that parenting is not just a workplace issue and that the current policies in medical education programs do not go far enough to protect their student parents and certainly do not encourage students to consider pursuing this dual role.

Undergraduate Policies

The following description of institutional policies in Canadian undergraduate medical education is based on a request for written policies regarding parenting, such as parental leave, childcare and breastfeeding policies, made to the fourteen English-language medical faculties across Canada.

Thirteen of the Faculties of Medicine responded to the request. Six have a written policy stating that undergraduate students may have a parental leave, while only five of these programs define the length and nature of the parental leave in detail.

Even if an explicit parental leave policy is not defined, the universities will allow a leave of absence for various reasons during the undergraduate medical school program. A leave of absence can be granted for academic and personal reasons and the details of the leave must be established on an individual basis. Many administrators prefer the flexibility that such a leave policy allows; decisions are made based on the student's needs as well as the requirements of the program without having to meet a set of rigid criteria such as the maximum time for completion of the program at the University of Calgary (Table 1). However, this creates a situation where there are no specific policies to support undergraduate student-parents.

The reference to "elective time" in Table 1 means that students would lose the opportunity to rotate through a specialty of their choice during the clerkship phase. The loss of this "elective" means that students won't be able to demonstrate an interest in a particular specialty which may negatively influence their opportunity to become a resident in that program, or it will deprive them of the opportunity to develop the specialized skills and knowledge from that rotation.

Three universities have unique policies related to parenting which are not yet duplicated at other centers. The University of Manitoba has created a guideline for medical students in clerkship who are pregnant. The guideline states that pregnant clerks will not do overnight call after 31 weeks gestation. This guideline is based on the policy for residents in that province. Memorial University has a policy regarding breastfeeding, allowing limited access to lectures and lecture-materials with a breastfeeding infant. However, none of the Universities explicitly support breastfeeding in clerkship training, for example, through the provision of facilities for breast-pumping. The Faculty of Medicine at Dalhousie University has a unique policy which protects the undergraduate student from paying additional tuition or fees during a parental leave which may require registration in an additional year of undergraduate medicine.

Regarding employment insurance, undergraduate medical students are university students and most do not work in

addition to their studies. Many programs have summer holidays for 1 or 2 years and most students will work for short times; however, during the clerkship component it is usually not possible to work at another job as well. Therefore, medical students taking parental leave do so without any government-provided employment insurance benefits. In addition, many medical students can face the additional risk of losing their student status depending on the length and timing of their leave. This can mean the loss of health benefits through the university as well as loans reverting to payment status, since they remain payment or interest free only while the student continues to be registered at a university. The burden of losing health benefits and paying back loans can strongly influence decisions about becoming a parent during medical school and about how much time to take off if a student is becoming a parent.

As medical students complete their undergraduate training and begin residency, the policy in support of parenting broadens considerably.

Postgraduate Policies

Medical resident training in Canada is a form of employment, therefore provincial and national labour codes and employment insurance benefits have an impact on the policies available to these postgraduate trainees. This ensures a much higher standard of available policy in support of student parents. The collective agreements from each provincial/regional professional association of residents and interns outline the policies having an impact on medical residents in Canada. The policies reviewed for this paper are those in effect as of March 2006. Some of the details of the parental leave available across the country are outlined in Table 2.

Regarding protection of the medical residents and their benefits, the collective agreements provide a guarantee that medical residents will not lose their jobs due to pregnancy. The majority of programs protect employment benefits such as a health plan, pension, vacation time, etc., for medical residents during their parental leave. Most of the collective agreements do not explicitly discuss the impact of a parental leave on registration at the university associated with the residency program. The loss of student status may be significant to medical residents in terms of their financial obligations to repay loans if they are no longer considered students. Only the Quebec collective agreement discusses this issue and clarifies that medical residents on parental leave will lose their student status.

Each collective agreement in Canada provides for a 1 year leave for female medical residents becoming parents, with the exception of Manitoba which offers a total of 26 weeks leave that can be extended on an individual basis. This leave is often a combination of pregnancy and parental leave and there are different policies available to parents who are adopting. The leave available to male medical residents includes a day or more of paid leave to attend the birth of their child and in some cases an unpaid parental leave is also available to them. Some collective agreements stipulate that the man must be the natural father of the child or that the couple must be composed of a man and a woman. These requirements do limit any flexibility for diverse family compositions including step-parents, same sex partners, or a single male parent.

Parental leave is most often in the form of unpaid leave from the employer. However, depending on the Provincial employment insurance regulations, female medical residents, and sometimes male, are able to apply for government Employment Insurance (EI) maternity/paternity leave benefits. Many of the collective agreements stipulate a period of service which the medical resident must meet before being eligible for the maternity leave benefits usually based on the EI requirements for the province. This is particularly the case with regards to financial top ups to the EI benefit. The top up is a supplement to the government benefit allowing the medical resident to continue making nearly the same income while on

leave for a short time. The details of these benefits are listed in Table 3.

These financial benefits have an important role in promoting a healthy approach to parenting because some medical residents may feel pressured to return to work when the salary supplements to the EI benefits end. The reduced or absent income during parental leave for students and residents with enormous debt payments from medical school may represent a significant financial pressure. This means a return to work within 3-6 months of giving birth, or even sooner. To reiterate, the workload involved in residency training can be very demanding and inflexible. An early return to work can be detrimental to the female medical resident in terms of physical health, poor mental health, early discontinuation of breastfeeding, poor bonding with their child and may have a negative impact on their relationship with their spouse or partner.

The data on length of maternity, paternity and parental leave actually taken by medical residents in Canada is not available. The factors that influence the length of leave are not exclusively financial. Taking off more than 6 weeks in a Family Medicine program, or 3 months in a longer residency program, can delay completion of residency training and licensing exams. These delays, as well as the issue of securing a job or starting a practice, also play a significant role in planning time off. Advancing in administrative or academic positions within the health care or university structures can also be adversely affected. The family commitment demonstrated by taking lengthy leaves from training and work have often been cited as the reason so few females hold senior academic positions in medical schools in Canada (Rich 1999). Although women now form the majority of undergraduate medical students, they have few female role models in senior academic and administrative positions in healthcare and certainly fewer mentors to demonstrate a creative approach to balancing their work and mothering.

Gender Roles

The parenting policies listed in the attached tables are organized according to gender largely because these are the categories used to delineate policy in the collective agreements. Much of the policy support for student parents in the form of leave, or financial supplements, is exclusively available to females. However, the inherently different roles of women and men in childbearing, breastfeeding and childrearing do need to be considered in light of these differences in policy. Caution needs to be taken by policy-makers to ensure that a woman's exclusive capacity to bear children does not generalize to an exclusive ability to raise them (Ranson 1998).

Policy can encourage shared parenting through such techniques as providing benefits that can be divided between either male or female parents. Policies such as those above providing 1 to 5 days off to a father upon the birth of his child imply that this is a reasonable amount of leave for a father to take. This type of policy supports the role of father as bread winner and mother as care giver. Providing a financial incentive to a mother to take at least 3 months off postpartum recognizes the unique role of the mother in childbearing. It provides time for recovery, particularly in the case of an operative delivery, or treatment in the case of postpartum depression, and provides appropriate time for the establishment of breastfeeding and bonding.

Another exclusive benefit available to women is a reduction in workload during pregnancy. This type of policy again recognizes the physical burden of the workload in residency and the negative impact it can have on the health of a woman who is pregnant. Over half of the collective agreements for medical residents in Canada guarantee a reduction in workload for those who are pregnant. In Ontario, Alberta and Manitoba pregnant medical residents are not required to perform overnight call duties after 31 weeks gestation. Pregnant medical residents in Newfoundland do not perform call duties at night and on weekends after 32

weeks gestation. In Quebec pregnant medical residents do not do overnight call after 24 weeks gestation and they are also granted a transfer if working conditions are considered hazardous (ie., radiation exposure, infection). The collective agreements for medical residents in the Maritime Provinces, British Columbia and Saskatchewan also allow working conditions to be modified on an individual basis but without policy clarifying what this modification should include and when the resident is eligible.

Parenting Policies

As described above, institutional policies in support of student parents in medical education in Canada may vary considerably depending on the program and level of training. The lived experiences of parenting in medicine vary depending on the life circumstances of the medical student/resident and the supportive environment they find in their program. This support is often dependent on their program director, current supervisor or the student's peers; it is not enshrined in institutional policy. Neither is it consistent, universal nor guaranteed.

The call to develop consistent and clear policies in support of student parents in medical training is being made by medical trainees, physicians and researchers in Canada and elsewhere (Cujec *et al.* 2000; Finch 2003; Palepu and Herbert 2002; Phillips 2000; "Resident Well-Being" 1998; Walsh *et al.* 2005). In view of this lobby, undergraduate medical programs in Canada are responding to the needs of their student parents by providing informal support, although the institutional atmosphere manifested by policy is lacking.

Medical residents in Canada have significantly better policy support for parenting than their undergraduate counterparts although conspicuous gaps are apparent. Flexibility in scheduling rotations and work hours in order to accommodate family responsibilities is a significant policy issue for postgraduate medicine. There is a clear need to protect the health of pregnant medical trainees through consistent policy ensuring modified working hours. The Society of Obstetricians and Gynaecologists of Canada has taken a lead in supporting pregnant medical residents by advocating a proactive approach for residency programs in developing flexible programs, using innovative technologies and developing policies to meet their needs (Murphy-Kaulbeck and McLeod 2000). Other significant gaps are policies in support of breastfeeding upon returning to clerkship/residency, childcare provision such as on-site daycare and parental leave policies in undergraduate medical programs.

There is a wide variety of types of parenting policies and a wide array of possibilities for the content and administration of such policies. The medical workplace, which includes medical trainees as well as physicians, has been slow to adapt its policies to childbearing and parenting (Walsh *et al.* 2005). It is clear that by providing poor institutional support, student parents can be left with a significant burden as they work to meet the demands of their medical studies and clinical responsibilities and to balance this with family life. The lifestyle of physicians, residents and medical students and the impact this has on caring for one's family is a particular concern for women as they struggle to meet the conflicting demands of traditional medical training and mothering.

Among physicians there is a common saying that there is no right time to have a child in medicine. This paper delineates current policy and reflects the poor support for work/life balance in medical education for women who choose to be parents. This is an unfortunate reality since the field of medical education, with its dedication to understanding and promoting health, must be at the forefront of promoting the health of its current and future practitioners.

Table 1: Parental Leave Policies in Undergraduate Medical Education, 2005

University	Parental leave?	Impact on graduation from medical school
Dalhousie University	1 extra year granted to finish the undergraduate program if a student becomes a parent.	Graduate 1 year later.
University of Calgary	Maximum time allowance to complete the curriculum: the first 2 years must be completed within 4 years of starting and the clerkship year must be completed 2 years later.	Graduate 1 or more years later.
McGill University	1. 8 week pregnancy leave taken from "elective time" or 1 week paternity leave. 2. 2-12 months leave of absence.	1st option will not impact graduation. The leave of absence will delay graduation.
University of Western Ontario	1. 12 months leave within the first 2 years. 2. 8 week leave in clerkship with rotations completed during time off before residency. 3. 4 weeks leave from "elective time" in clerkship.	1st option will delay graduation by 1 year. The short leaves in clerkship will not impact graduation.
Queen's University	1. No time off can be accommodated in first 2 ½ years. 2. 4 weeks of leave in clerkship.	The 2nd option will not impact graduation.
McMaster University	Leave for adoption or birth must be requested on an individual basis.	No written policy
University of Toronto	No written policy. Individual basis only for interruptions to program for >2 weeks (reasons for leave are not listed).	No written policy
Memorial University	No written policy	No written policy
University of Manitoba	No written policy	No written policy
University of Alberta	No written policy	No written policy
University of Saskatchewan	No written policy	No written policy
University of Ottawa	No written policy	No written policy
University of British Columbia	No written policy *Policy in development	No written policy

Table 2: Parental Leave Policies, Postgraduate Medicine

Union	Parental Leave: female	Parental Leave: male
PARIN* (Nfld.)	Maternity: 52 weeks unpaid leave. Starts after 32 weeks gestation.	3 days paid "family leave" per year.
PARI-MP* (Maritime Provinces)	Pregnancy: 17 weeks unpaid leave. Starts after 24 weeks gestation. Parental/adoption: 35 weeks unpaid leave. Must be employed for 1 year before this benefit is accessed.	Birth/adoption: 7 days paid leave. Parental/adoption: 35 weeks unpaid leave. Must be employed for 1 year before this benefit is accessed.
FMRQ* (Quebec)	Maternity: 20 weeks unpaid leave. Starts after 30 weeks gestation. Pregnancy-related health care: 4 days paid leave for appointments. Adoption: 10 weeks paid leave. All parental leave can be extended to a maximum of 2 years total unpaid leave.	*spouse limited to heterosexual couples. Paternity: 5 days paid leave. Adoption: 10 weeks paid leave. All parental leave can be extended to a maximum of 2 years total unpaid leave.
PAIRO* (Ontario)	Pregnancy: 17 weeks unpaid leave. Extended to a total of 52 weeks including parental leave. Parental/adoption: 37 weeks unpaid leave.	Parental (*natural father or adopted): 37 weeks unpaid leave. Can be extended to a total of 52 weeks.
PARIM* (Manitoba)	Maternity: 2 days paid leave + 26 weeks unpaid leave. Adoption: 2 days paid leave + 17 weeks unpaid leave.	Parental/adoption: 2 days paid leave + 17 weeks unpaid leave.
PAIRS* (Sask.)	Maternity/adoption: 18 weeks unpaid leave + 34 weeks unpaid parental leave. Parental: 37 weeks unpaid leave. Must be employed >20 weeks.	Paternity: 5 days paid leave. Parental: 37 weeks unpaid leave. Must be employed > 20 weeks.
PARA* (Alberta)	Maternity: 18 weeks unpaid leave. Starts after 32 weeks gestation. Parental leave: total of 52 weeks unpaid leave (including pregnancy leave) Adoption: 2 weeks paid leave.	Paternity: 1 day paid leave + 4 days unpaid leave. Adoption: 2 weeks paid leave. Parental: total of 52 weeks unpaid leave.
PAR-BC* (British Columbia)	Maternity/parental: 52 weeks unpaid leave. Starts after 29 weeks gestation. Adoption: 37 weeks unpaid leave.	Paternity: 1 day paid leave. Parental (*natural father)/adoption: 37 weeks unpaid leave.

*PARIN: Professional Association of Residents and Interns of Newfoundland, *PARI-MP: Professional Association of Residents and Interns of the Maritime Provinces, *FMRQ: Federation Medecins Residents Quebec, *PAIRO: Professional Association of Interns and Residents of Ontario, *PARIM: Professional Association of Residents and Interns of Manitoba, *PAIRS: Professional Association of Interns and Residents of Saskatchewan, *PARA: Professional Association of Residents of Alberta, *PAR-BC: Professional Association of Residents of British Columbia.

Table 3: Benefits Associated with Parental Leave, Postgraduate Medicine

Association	Benefits: female	Benefits: male
PARIN (Nfld.)	Employment benefits maintained.	
PARI-MP (Maritime Provinces)	Employment benefits maintained. Top up of EI benefits to 93% of usual pay for 15 weeks of pregnancy leave. Must be employed >1 year.	Employment benefits maintained. Top up of EI benefits to 93% of usual pay for 15 weeks of adoption leave. Must be employed >1 year.
FMRQ (Quebec)	Employment benefits maintained. Top up of EI benefits to 95% for 20 weeks. Must be employed > 20 weeks. Loss of student status.	Employment benefits maintained. Loss of student status.
PAIRO (Ontario)	Employment benefits maintained. Top up of EI benefits to 75% of usual pay for 25 weeks. Must be employed > 13 weeks.	Employment benefits maintained. Top up of EI benefits to 75% of usual pay for 25 weeks. Must be employed >13 weeks.
PARIM (Manitoba)	Manitoba Medical Association Maternity/Parental Benefits Program	Manitoba Medical Association Maternity/Parental Benefits Program
PAIRS (Sask.)	Employment benefits maintained. Top up of EI benefits to 90% of usual pay for full period of EI benefit. Must be employed > 20 weeks.	Employment benefits maintained.
PARA (Alberta)	Employment benefits maintained for pregnancy/ adoption leave.	Employment benefits maintained for paternity/ adoption leave.
PAR-BC (British Columbia)	Employment benefits maintained. Top up to 85% of usual pay for 17 weeks of maternity leave.	Employment benefits maintained.

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